Screen Date_____

West Virginia Department of Health
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

2 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ Yes ☐ No _____

Newborn metabolic screen ☐ NL ☐ Results in child's record

Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____

☐ Results in child's record

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

Psychosocial/Behavioral

What is your family's living situation?_____

_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care plans? _____

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Sever

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

Maternal Depression/Patient Health Questionnaire (PHQ-2)

Positive screen = numbered responses 3 or greater

If positive, see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS)

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Little interest or pleasure in doing things

☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ Child smiles responsively ☐ Child makes sounds that let you know if he/she is happy

Verbal Language (Expressive and Receptive) ☐ Child makes short cooing sounds

Gross Motor ☐ Child lifts head and chest when on stomach ☐ Child keeps head steady when held in sitting position

Fine Motor ☐ Child can open and shut hands ☐ Child can briefly bring hands together

_____

_____

Continue on page 2

Name______________________________ DOB______________________ Age____________ Sex: ☐ M ☐ F

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Oral Health

Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep

☐ Breastfeeding - Frequency ____________________

☐ Bottle feeding - Amount______________ Frequency_________

☐ Formula ____________________

☐ Normal elimination____________________

☐ Normal sleeping patterns____________________

☐ Place on back to sleep____________________

☐ Sleeps 3 to 4 hours at a time____________________

Concerns and/or questions____________________

____

Hepatitis B Risk *(See Periodicity Schedule for Risk Factors)*

☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	______________
Skin	☐ N	☐ Abn	______________
Neurological	☐ N	☐ Abn	______________
Reflexes	☐ N	☐ Abn	______________
Head	☐ N	☐ Abn	______________
Fontanelles	☐ N	☐ Abn	______________
Neck	☐ N	☐ Abn	______________
Eyes	☐ N	☐ Abn	______________
Red Reflex	☐ N	☐ Abn	______________
Ocular Alignment	☐ N	☐ Abn	______________
Ears	☐ N	☐ Abn	______________
Nose	☐ N	☐ Abn	______________
Oral Cavity/Throat	☐ N	☐ Abn	______________
Lung	☐ N	☐ Abn	______________
Heart	☐ N	☐ Abn	______________
Pulses	☐ N	☐ Abn	______________
Abdomen	☐ N	☐ Abn	______________
Genitalia	☐ N	☐ Abn	______________
Back	☐ N	☐ Abn	______________
Hips	☐ N	☐ Abn	______________
Extremities	☐ N	☐ Abn	______________

Signs of Abuse/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Parental/Family Health and Well-Being, Infant Behavior and Development, Nutrition and Feeding, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

____

Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

☐ Hepatitis B Screen (HBsAG) *(if high risk)*

☐ Other ____________________

Referrals ☐ Maternal depression - **Help4WV.com/1-844-435-7498**

☐ Developmental

☐ Other ____________________

☐ Right from the Start (RFTS) **1-800-642-9704**

☐ Birth to Three (BTT) **1-800-642-9704**

☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

☐ Women, Infants and Children (WIC) **1-304-558-0030**

Medical Necessity

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.

Follow Up/Next Visit ☐ 4 months of age

☐ Other____________________

☐ Screen has been reviewed and is complete

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Please Print Name of Facility or Clinician

West Virginia Department of HEALTH